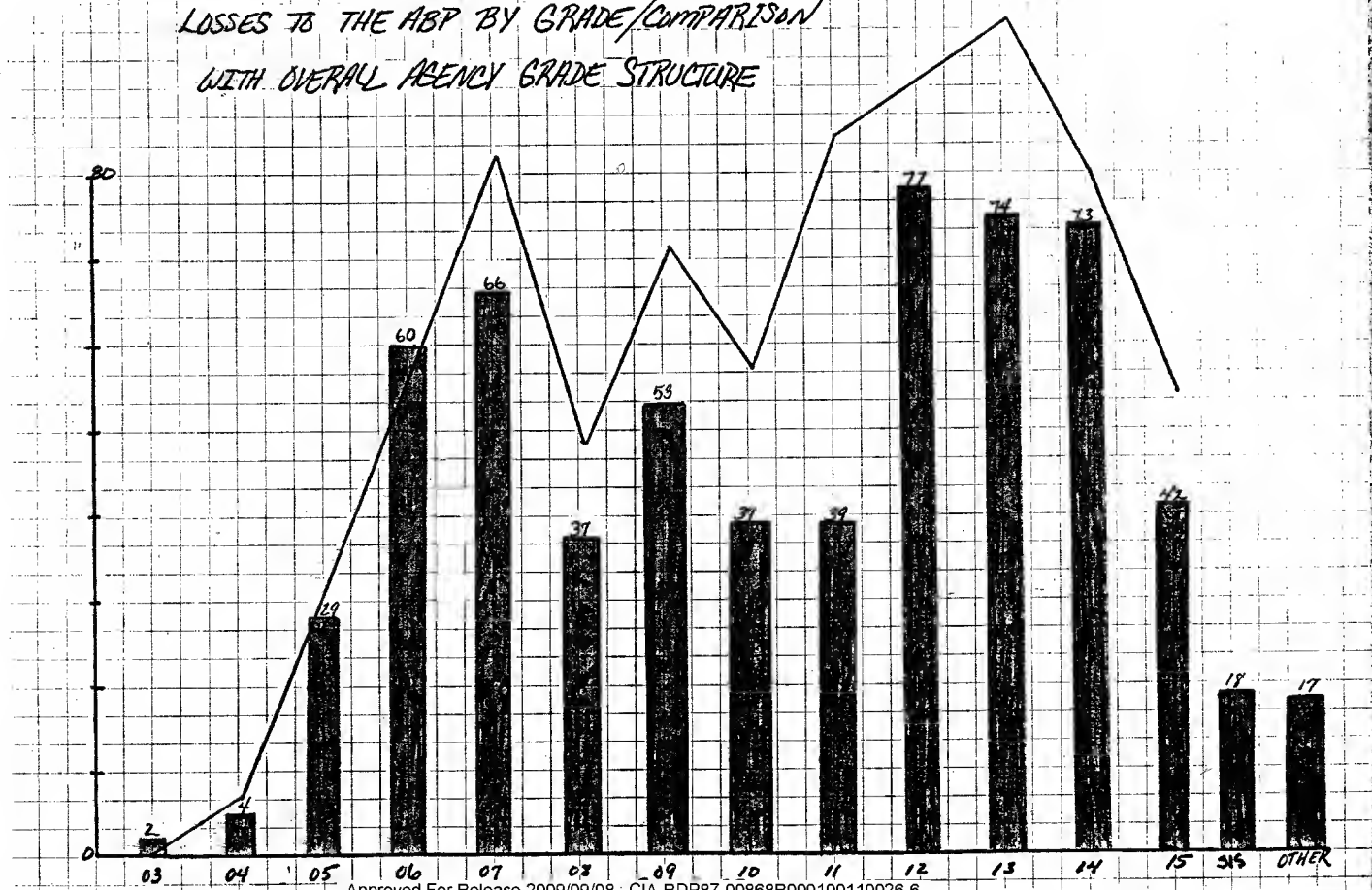
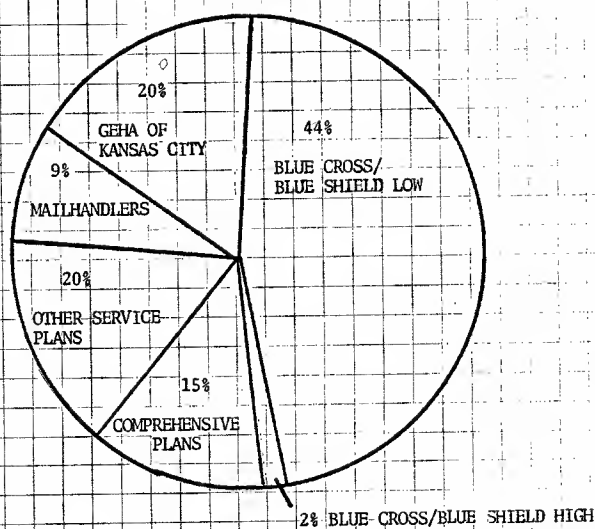


*LOSSES TO THE ABP BY GRADE/COMPARISON
WITH OVERALL AGENCY GRADE STRUCTURE*





ABP LOSSES TO OTHER PLANS
WHERE DID THEY GO?

FEHB Plan Comparison Chart

For benefits beginning on January 1, 1984

Fee For Service Plans

Abbreviations:
C&R—Customary & Reasonable
CY—Calendar Year
IP—Inpatient
LM—Lifetime Maximum

MHC—Mental Health
C&R—Catastrophic
OP—Outpatient Plan
R&B—Room and Board
SA—Scheduled Allowance

Plan Name, Brochure Number (BRI-4 f), and Option	Catastrophic Protection		Inpatient Services—Plan Pays:			Outpatient Services—Plan Pays:			Mental Health Services—Plan Pays: (after started deductible)		Other Benefit Features (see key below)	General Deductible per Calendar Year	
	MED/SURG Max. Covered Out-of-Pocket person/family	MENTAL HEALTH Inpatient Only up to LM per person	Hospital Care	Surgery C&R	Doctors Visits C&R	Surgery C&R	Diagnostic Tests C&R	Doctors Visits C&R	Inpatient Care	Outpatient Care		Per Person	Per Family
Association Benefit Plan	\$1,000/\$1,000/f	Med/Surg. Catastrophic applies	100% for 365 days, \$200 Ded./admission	80%	80%	100%	80%	80%	\$200. Plan Ded/admission, 100% for 60 days, then 80% No LM	50% / 50 visits CY per person	6, 8, 10, 12	\$200	Two
Service Benefit (25) (Blue Cross/Blue Shield)	Hi	\$1,500/\$1,500	\$4,000 ^l	100% No Day Limit \$50 DED/admission	80%	80%	100%	80%	\$50 DED/adm, 80% to MHC; then 100% to \$75,000 LM ^k	70% up to 50 visits/CY ^t	5-7-8-12	\$200	Two
	Std	\$2,500/\$2,500	None	100% No Day Limit; \$125 DED/admission	75%	75%	75%	75%	\$100 DED/adm, 75% to 30 days/CY; \$50,000 LM ^k	75% up to 25 visits/CY ^t	4-7-8-12	\$250	Two
GEHA (48)	\$2,000/\$2,000 ^f	\$8,000 ^l	100% R&B, 80% Other IP	80%	80%	85%	85%	85%	\$500 CY DED, 50% to MHC; then 100% to \$50,000 LM	Up to \$25/visit, to 30 visits/CY	1-6-8-9-12	\$200	Three
Mail Handlers (163)	Hi	\$2,500/\$5,000	\$5,000	100% No Day Limit; \$125 DED/admission	SA ^m	SA ^m	SA ^m	SA ^m	\$100 CY DED, 100% to \$2,500, then 0 to \$5,000 MHC; then 100% to \$25,000 LM	None	4-6-8-9	N/A	N/A
	Std	\$2,500/\$5,000	\$5,000	100% No Day Limit; \$125 DED/admission	SA ^m	SA ^m	SA ^m	SA ^m	\$100 CY DED, 100% to \$2,500 then 0 to \$5,000 MHC; then 100% to \$25,000 LM	None	6-8-9	N/A	N/A

		1984 Monthly Rates Your Share		1984 Bi-weekly Rates Your Share	
		Self Only	Family	Self Only	Family
Association Benefit Plan		\$35.78	104.03	16.51	48.01
Service Benefit (25) (Blue Cross/ Blue Shield)	Hi	65.12	140.97	30.05	65.06
	Std	15.58	37.16	7.19	17.15
GEHA (48)		22.26	41.09	10.27	18.96
Mail Handlers (163)	Hi	15.12	42.95	6.98	19.82
	Std	13.57	32.10	6.26	14.82

Footnotes:

a. up to \$5,000

b. \$100 DED/admission

c. for first \$500, then 75%

d. 80% w/e 2nd opinion

e. 80% for elective

f. 100% for x-ray to \$150

g. to contract's limit

h. after \$100 DED

i. DED included under catastrophic

k. LM applies to IP and OP

l. C&R does not apply

Key:

1. Routine Physicals & Immunizations

2. Extended Care Facility

3. Preventive Dental Care for

4. Dental Care

5. Home Health Care

6. Alcohol/Drug Abuse Care

7. Alcohol/Drug Detox. Only

8. Midwives

9. Chiropractors

10. Hospice Care

11. Vision Care

12. Prescription Drugs

Annualized Premiums and Comparison with ABP

	<u>Self</u>	<u>Self & Family</u>	<u>Difference</u>	
			<u>Self</u>	<u>Self & Family</u>
ABP	\$429.26	\$1,248.26		
BC/BS HIGH	\$781.30	\$1,691.56	+\$352.04	+\$443.30
BC/BS LOW	\$186.94	\$ 445.90	-\$242.32	-\$802.36
GEHA (KC)	\$267.02	\$ 492.96	-\$165.24	-\$775.30
Mailhandlers HIGH	\$181.48	\$ 515.32	-\$247.81	-\$732.94
Mailhandlers LOW	\$162.76	\$ 385.32	-\$266.50	-\$862.94

Dental Care Benefits (High Option Only) MAILHANDLERS

HIGH OPTION PAYS—For each covered dental procedure

Actual charges, up to amounts specified in Schedule of Dental Allowances. The maximum benefit is \$725 per person, \$1,450 per family per calendar year

WHAT IS COVERED

Subject to the definitions, exclusions, and limitations in this brochure, the High Option of this Plan will pay Dental Care Benefits, as shown at the left, for the dental procedures specified in the following Schedule of Dental Allowances.

WHAT IS NOT COVERED

- Denture replacements less than 5 years after the last one for which benefits have been paid
- Orthodontic care
- Temporary services
- Oral hygiene instruction

Schedule of Dental Allowances

Diagnostic

Annual examination (oral check)	\$7.00
Complete intraoral series of X-rays	20.00
Intraoral periapical (first film)	3.00
Each additional single film	2.00
Occlusal view X-ray	7.00
Lateral jaw X-ray each	12.00
Four bitewing X-ray films	10.00
Antero-posterior X-ray of head and jaws	12.00
Panoramic, including bitewings	20.00
Maximum allowance for X-rays and their interpretation (limit per calendar year)	20.00

Preventive (limit per calendar year)

Oral prophylaxis, child to age 12	\$11.00
Over age 12	13.00
Topical Fluoride Treatment	7.00

Dental Care

Restorative services (includes bases and analgesia)

1 surface	12.00
2 surfaces	19.00
3 surfaces or more	25.00
Reinforcement pins—1st pin	7.50
Each additional pin (maximum three pins)	5.25

Endodontics

Vital pulpotomy, or pulpcap	\$15.00
Single root canal filling	88.00
Double root canal filling	124.00
Triple root canal filling	162.00
Apicectomy	50.00

Periodontics

Subgingival curettage and root planing—per quadrant	12.00
Treatment of Vincent's infection	12.00
Occlusal adjustment	12.00
Bite equilibration	12.00
Maximum allowance per calendar year	96.00

LIMITATION: If in the construction of a denture, or any prosthetic appliance, the patient and the dentist decide on personalized restoration, or to employ special techniques as opposed to standard procedures, the benefit provided will be limited to the amount payable for the standard procedures.

Crown and Bridge

Inlay/Onlay (Gold)	\$62.00
Acrylic or vinyl jacket crown	99.00
Porcelain jacket crown	124.00
Acrylic veneer jacket crown	124.00
Porcelain veneer jacket crown	162.00
Cast gold full crown	136.00
¾ cast gold crown	93.00
Crown, stainless steel	31.00
Pontics:	
Cast gold (sanitary)	75.00
Steel's facing	93.00
Tru-pontic type	99.00
Plastic processed to gold	124.00
Gold dowel and core	62.00
Post and core	31.00
Recementing crown	12.00
Recementing fixed bridge	25.00
Replacing facing (slot and tube)	25.00

Dentures (Prosthetics)

Full upper or lower acrylic denture including necessary adjustments within 6 months	218.00
Immediate denture including chairside re-lines and necessary adjustments within 6 months	248.00

Partial acrylic base denture, two clasps with rests	\$198.00
Cast base chrome partial—two clasps, with rests	248.00
Wrought lingual bar—2 wrought clasps, acrylic saddle	198.00
Each additional clasp with rest	31.00
Denture repair—no teeth	19.00
Repair of denture base plus replacing one tooth	25.00
Replacing each additional tooth	9.00
Replacing broken tooth—no other repair	12.00
Add tooth to partial, replacing extracted tooth	31.00
Partial acrylic denture, replacing one or two teeth, no clasps (Flipper or Stay Plate)	93.00
Replacing one arm of a clasp	31.00
Replacing broken clasp with new clasp	37.00
Rebase or reline of denture	62.00

Oral Surgery (includes local anesthesia)

Extraction of tooth, uncomplicated	13.75
Each additional permanent tooth at same session	11.00
Each additional deciduous tooth at same session	10.00

Surgical-extraction of erupted tooth	\$21.00
Each adjacent tooth surgically removed during same session	16.00
Surgical removal—impacted teeth:	
Complete bony impaction	62.00
Partial bony impaction	44.00
Soft tissue impaction	31.00
Repair/Alveolectomy per jaw	40.00
Incision and drainage of abscess	12.00
Gingivectomy (per quadrant)	93.00
Osseous surgery, including gingivectomy (per quadrant)	125.00
Frenectomy	56.00
Removal of cyst	60.00

Miscellaneous Services

Anesthesia—general in office, by qualified person:	
1st hour	16.00
each additional 30 minutes	8.00
Consultation by other than the attending dentist	19.00
Palliative treatment of dental pain (per visit)	7.00
Space maintainer (up to age 19)	31.00
Biopsy	31.00
Periodontal provisional splints	74.00

Dental Benefits—Standard (Low) Option

Subject to the exclusions, limitations, and definitions in this brochure, the Plan will pay actual charges up to the amount specified in the Schedule of Dental Allowances for the following covered dental procedures.

SCHEDULE OF DENTAL ALLOWANCES—

Clinical Oral Examinations

Initial oral examination	\$ 7.25
Periodic oral examination.....	6.00
Emergency oral examination.....	7.25

Radiographs

Intraoral-complete	\$19.00
Intraoral periapical-single, first film.....	3.50
Intraoral periapical-each additional film.....	2.00
Intraoral-occlusal film	6.00
Extraoral-single film.....	8.50
Extraoral-each additional film	3.00
Bitewing-single film	4.75
Bitewings-two films	7.25
Bitewings-three films.....	8.75
Bitewings-four films.....	10.00
Posteroanterior and lateral skull and facial bone, survey film	24.00
Panoramic-maxilla and mandible film	19.25

Tests and Laboratory Examinations

Pulp vitality tests	\$ 4.25
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Palliative Treatment

Palliative (emergency) treatment of dental pain, minor procedures	\$12.00
Fillings (sedatives).....	12.00

Amalgam Restorations (Including Polishing)

Amalgam-one surface, deciduous	\$10.00
Amalgam-two surfaces, deciduous.....	14.50
Amalgam-three surfaces, deciduous	19.00
Amalgam-four surfaces, deciduous	23.00
Amalgam-one surface, permanent.....	11.50
Amalgam-two surfaces, permanent	17.50
Amalgam-three surfaces, permanent.....	23.50
Amalgam-four surfaces or more, permanent	26.50
Pin retention-exclusive of amalgam (per tooth).....	6.00

Silicate Restoration

Silicate cement per restoration	\$ 8.00
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Acrylic or Plastic or Composite Restorations

Acrylic or plastic or composite resin (any number of surfaces)	\$11.50
Acrylic or plastic or composite resin-one surface	11.50
Acrylic or plastic or composite resin-two surfaces	17.50
Acrylic or plastic or composite resin-three surfaces.....	23.50
Pin retention-exclusive of composite resin (per tooth) ..	6.00
Acrylic or plastic or composite resin-involving incisal angle	18.50

Gold Inlay Restorations

Inlay-gold, one surface, permanent	\$11.50
Inlay-gold, two surfaces, permanent	17.50
Inlay-gold, three surfaces, permanent	23.50

Dental Prophylaxis

Adult	\$12.00
Children.....	10.25

Fluoride Treatments

Topical application of fluoride (including prophylaxis)—child	\$17.50
Topical application of fluoride (including prophylaxis)—adult	19.25
Topical application of sodium fluoride, 4 treatments (excluding prophylaxis).....	12.50
Topical application of sodium fluoride, 4 treatments (including prophylaxis).....	21.50
Topical application of stannous fluoride, 1 treatment (excluding prophylaxis).....	7.25
Topical application of stannous fluoride, 1 treatment (including prophylaxis).....	17.50
Topical application of acid fluoride phosphate, 1 treatment (excluding prophylaxis).....	7.25
Topical application of acid fluoride phosphate, 1 treatment (including prophylaxis)	17.50

Space-Management Therapy

Fixed-unilateral type	\$36.00
Fixed-bilateral type	54.00
Removable-unilateral type	36.00
Removable-bilateral type	54.00
Recementation of space maintainer.....	8.50

Gold Foil Restorations

Gold Foil-one surface, permanent	\$11.50
Gold Foil-two surfaces, permanent	17.50
Gold Foil-three surfaces, permanent	23.50

Porcelain Restoration

Inlay-porcelain	\$11.50
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Extractions-Includes Local Anesthesia and Routine Post-operative Care

Single tooth.....	\$13.00
Each additional tooth	12.00

Surgical Extractions-Includes Local Anesthesia and Routine Postoperative Care

Surgical removal of erupted tooth, requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth (Extraction of tooth, erupted)	\$17.00
Root recovery (surgical removal of residual root)	28.00

Anesthesia

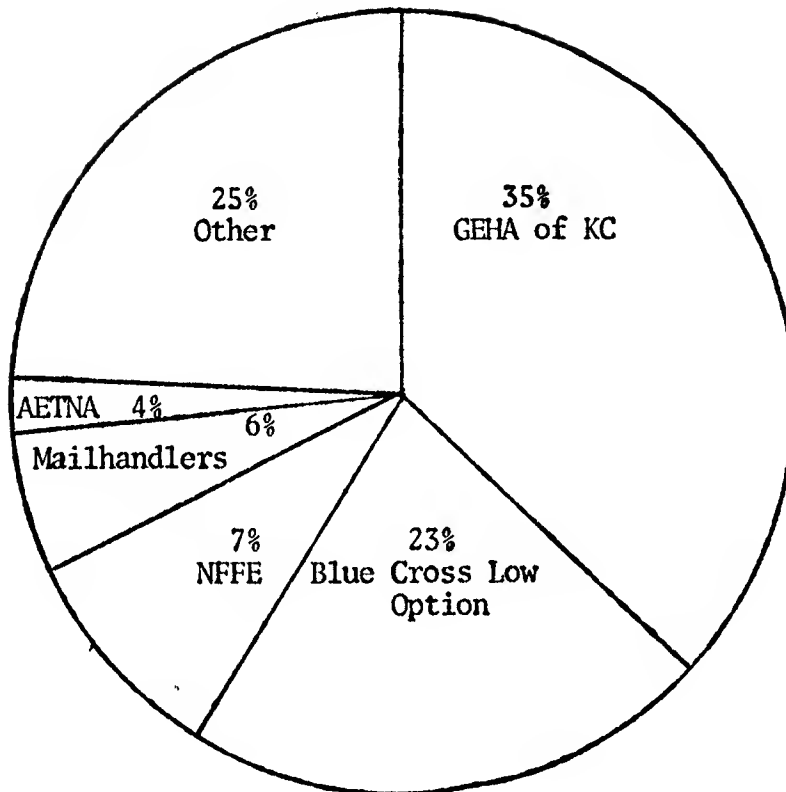
General anesthesia in connection with covered extractions.....	\$22.00
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Hospital benefits are available in connection with any of these dental procedures only as described on page 5.

CIARDS RETIREE CHANGES

FROM ABP

TOTAL



LOYALTY QUESTION

DID THE 1984 CHANGES OVERCOME LOYALTY INERTIA?

31 % of the losses were
policyholders with 10 or
more years of continuous
ABP participation.

WHAT DID WE LOSE?

1983 USE PROFILE OF LOSSES

STAT

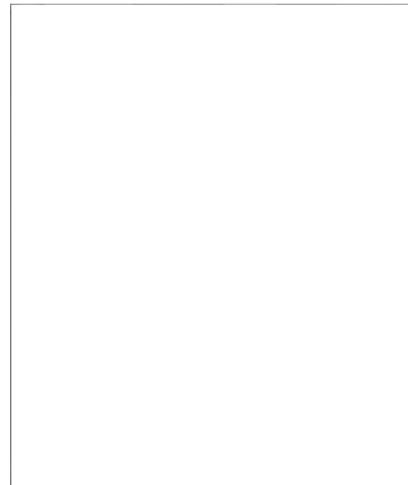
NUMBER WHO MET AT
LEAST ONE DEDUCTIBLE

NUMBER WHO USED SURGICAL/
INPATIENT BENEFIT

NUMBER WHO USED MENTAL
& NERVOUS BENEFITS

NUMBER WHO USED SPECIAL
OUTPATIENT BENEFIT

NUMBER WHO HAD MINIMAL
OR NO BENEFIT USE



1984 TOTAL LOSS IN PREMIUMS

<u>Self</u>	<u>Self & Family</u>	<u>Total</u>
#	#	#
\$	\$	Total
\$216,496	\$1,038,080	\$1,254,576

STAT

ABP

Open Season Statistics

(preliminary)

STAT

New Applications

Cancellations

Losses to Other Plans

Gains to ABP

TOTAL

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